**NAME OF STUDENT: D.O.B.: HOMEROOM/GRADE:**

*SIS requires that your child is immunized and receives a comprehensive physical examination BEFORE entering SIS. Please return this form to school PRIOR TO the student’s start date at SIS.*

# PART 1: PARENT/GUARDIAN AUTHORIZATION

I hereby certify, to the best of my knowledge, that the information I have provided in this form is true and correct. If false or not updated or misleading the information has been provided, SIS has the right to annul my child’s enrollment at SIS.

I request medication(s) be given during school hours as ordered by my child’s physician. I also request the medication(s) be given to the ﬁeld trips, as prescribed.

I will notify the school of any change in the medication(s).

I give permission for the medications to be given by the school personnel as delegated, trained, and supervised by the school nurse.

I give permission for the school nurse to communicate, as needed, with school staﬀ about my child’s medical conditions(s) and the treatment prescribed. It is parental responsibility to update medical records every 3 years***.***

# PART 2: EMERGENCY CARE PERMISSION

Permission is hereby given for emergency measures to be taken in case of an accident or sudden illness with the understating that I will be notiﬁed as soon as possible.

I acknowledge that it is my responsibility to inform the Seoul International School Health Oﬃce of any changes in my child’s health, physical condition, or medical needs. I give permission to SIS to release appropriate medical information to the hospital in case of an emergency.

# PARENT/GUARDIAN SIGNATURE: Date:

TO BE COMPLETED BY THE PARENT OR GUARDIAN and bring ALL parts of this Form to your child’s physician to make confirm.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT INFORMATION** | | | | | | | | | | | | |
| STUDENT’S NAME (Last, First): | | | DATE OF BIRTH (MM/DD/YYYY): | | | BLOOD TYPE: | | SEX: | | | HOMEROOM (GRADE): | |
|  | | |  | | |  | | Male ( ) Female ( ) | | |  | |
| Father/Guardian’s Name (Last, First): | | | Cell #: | | | Mother/Guardian’s Name (Last, First): | | | | | Cell #: | |
|  | | |  | | |  | | | | |  | |
| Home Address: | | | | | Home Phone #: | | | Email : | | | | |
|  | | | | |  | | |  | | | | |
| **Emergency Contact (Other than parents):**  Name: (Relation: ) Contact number: | | | | | | | | | | | | |
| **PAST OR PRESENT MEDICAL HISTORY** | | | | | | | | | | | | |
| **Does the child/student have a past or present medical history of the following?** | | | | | | | | | | | | |
| ADD/ADHD |  Y  N | Epilepsy/Seizure Disorder | | |  Y  N | | Hearing Problems | |  Y  N | Skin Problems | |  Y  N |
| Anxiety Disorder |  Y  N | Frequent Headaches | | |  Y  N | | Heart Disorder | |  Y  N | Speech Diﬃculty | |  Y  N |
| Chicken Pox |  Y  N | Frequent Nosebleeds | | |  Y  N | | Hepatitis A/B/C | |  Y  N | Vision Problems | |  Y  N |
| Diabetes |  Y  N | Gastrointestinal Disorder | | |  Y  N | | Scoliosis | |  Y  N | *Others:* | |  Y  N |
| **If you have checked on any of the above medical history, please explain in detail:** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Does your child have allergies?**  **Y**  **N** | | | | | | | | | | | | |
| ***If YES,*** student is allergic to: | | |  | | | | | | | | | |
| Reactions the student may have: | | |  | | | | | | | | | |
| Treatments the student may need after exposure: | | |  | | | | | | | | | |
| **Does your child have asthma?**  **Y**  **N** | | | | | | | | | | | | |
| ***If YES,*** does the student need an inhaler? | | | |  Y  N | | | | | | | | |
| If the student needs an inhaler, please indicate if the inhaler will: | | | |  remain with the student or  be provided to the Health Oﬃce for emergency use. | | | | | | | | |
| **If your child have other signiﬁcant health conditions that may require emergency medical care at school, child care, ﬁeld trip or sports activity, please explain in detail:** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

TO BE COMPLETED BY THE PARENT OR GUARDIAN and bring ALL parts of this Form to your child’s physician to make confirm. Please return this form to nurse office PRIOR TO the student’s start date at SIS.

# PART 3: Medication Authorization

**NAME OF STUDENT: D.O.B.: HOMEROOM/GRADE:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medication Permission** | | | | | | | | | |
| **Please check the following list of common medications which Health Oﬃce may administer to your child as needed at school.** | | | | | | | | | |
| Acetaminophen (Tylenol) - pain and fever relief | | | |  Y  N | Hexamedine/Tantum spray for sore throat | | | |  Y  N |
| Ibuprofen (Advil) - pain relief and anti-inﬂammatory | | | |  Y  N | Cegaton Troche - sore throat, stomatitis | | | |  Y  N |
| Zyrtec (tablet) - allergy (Nasal/Sinus Congestion) | | | |  Y  N | Festal Plus— stomach indigestion | | | |  Y  N |
| Almagel suspension- Antiacid | | | |  Y  N | Smecta suspension- stomach pain and diarrhea | | | |  Y  N |
| **Please list any medication the student takes on a regular basis at home:** | | | | | | | | | |
|  | | | | | | | | | |
| **This is ONLY for the student who needs to prepare SELF-medication(s) at the nurse’s office during school hours for an emergency use related to the child’s current disease and/or condition. (Ex: Asthma-Inhaler, Allergy-EPIPEN, Diabetics, Insulin/Glucagon, etc.)** | | | | | | | | | |
| Physician order for administration of medication by school personnel:  **Medical Condition(s):** | | | | | | | | | |
| Name of Medication: | | | | | Name of Medication: | | | | |
| *Dose:* | *Time to given:* | | *Route:* | | *Dose:* | *Time to given:* | | *Route:* | |
| *Possible side effects:* | | | | | *Possible side effects:* | | | | |
| *Start date:* | *Stop date:* | | *Refrigeration required?* | | *Start date:* | *Stop date:* | | *Refrigeration required?* | |
| *Physician Signature:* | | *Date:* | | | *Physician Signature:* | | *Date:* | | |
| *Clinic:* | | | *Phone:* | | | *E-mail/ Fax:* | | | |

# PARENT/GUARDIAN SIGNATURE: Date:

**PHYSICIAN’S EXAMINATION**

**(MEDICAL EXAM MUST BE WITHIN 6 MONTHS OF ENTRY DATE)**

Name (Last, First) Grade Date of Birth (MM/DD/YY) Sibling at SIS (name/grade)

(Blood Pressure only for students age 11 and older)

□ YES / □ NO

Corrective Lens

Both

Vision R: L:

Blood Pressure /

Pulse

Weight Kg

Height cm

## (O) Normal (X) Abnormal (Comment: Specify consultation requested)

|  |  |  |  |
| --- | --- | --- | --- |
| Ears/Hearing |  | Musculoskeletal |  |
| Nose |  | Spine |  |
| Mouth |  | Skin |  |
| Throat |  | Neurological |  |
| Neck |  | Nutritional |  |
| Heart |  | Emotional / Psychological |  |
| Lungs |  | Behavior |  |
| Abdomen |  | Speech |  |
| Physician’s Comments : | | | |

Please list any medication the student takes on a regular basis.

**This student is physically able to participate in all physical education**

**and sports activities : □ YES / □ NO**

If NO, Please explain :

**If TB skin test result is positive, either chest X-ray or TB blood test(IGRA) is required regardless of previous BCG vaccination. - All students enrolled at SIS are required to have PPD skin test OR chest X-ray OR IGRA every 2-3 years.**

|  |  |  |
| --- | --- | --- |
| Required tests | Date (MM/DD/YY) | Result |
| Tuberculosis Skin Test or Chest X-ray  or IGRA |  | TB skin test: Chest X-ray:  TB blood test(IGRA): |
| HEMOGLOBIN (6yrs old~) |  |  |
| URINALYSIS (6yrs old~) |  |  |

**SIS requires evidence of immunization for the following.**

**I have seen evidence that these have been administered**. □ YES / □ NO

\* Please indicates the EXACT DATES (MM/DD/YY) of vaccinations received.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DT&P #1 / / | OPV/IPV | #1 / / | MMR | #1 / / |
| #2 / / |  | #2 / / |  | #2 / / |
| #3 / / |  | #3 / / | HepB | #1 / / |
| #4 / / |  | #4 / / |  | #2 / / |
| #5 / / | Varicella | #1 / / |  | #3 / / |
|  |  | #2 / / | Td/ | 11-12 years |
|  |  | # Dz / / | Tdap | #1 / / |

**NOTE TO THE PHYSICIAN** : Please be strict on immunization. Students who have lost records must have the OPV booster, one DTap or Td (if between ages 11 and 18) booster, and one MMR booster along with the annual Tuberculin Skin Test. Please administer appropriate immunization for incomplete records.

Thank you.

|  |  |
| --- | --- |
| Physician’s Name | Signature |
| Hospital | Date |